

**CAFETERIA PLAN DOCUMENT FOR FLEXIBLE SPENDING, HEALTH, DENTAL AND VISION
BENEFITS FOR EMPLOYEES, AND DEPENDENTS OF THE STATE OF IDAHO
STATE OF IDAHO DEPARTMENT OF ADMINISTRATION - OFFICE OF GROUP INSURANCE**

STATE OF IDAHO DEPARTMENT OF ADMINISTRATION - OFFICE OF GROUP INSURANCE

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STATE OF IDAHO DEPARTMENT OF ADMINISTRATION - OFFICE OF GROUP INSURANCE

INTRODUCTION

The State of Idaho, Department of Administration - Office of Group Insurance (the "State") has amended its Benefits Plan (the "Plan") effective July 1, 2022 to provide benefits for eligible Employees, their Dependents. The concept of this Plan is to allow eligible Employees to choose among different types of benefits based on their own particular goals, desires, and needs. This Plan is a restatement of a Plan which was originally effective on July 1, 1982.

The intention of the State is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

ARTICLE I DEFINITIONS

1.1 **"Administrator"** means the Idaho Office of Group Insurance within the Idaho Department of Administration or entity that has been designated by the Administrator pursuant to Section 9.1 to administer the Plan on behalf of the Administrator.

1.2 **"Benefit" or "Benefit Options"** means any of the optional benefit choices available to a Participant as outlined in Section 4.1.

1.3 **"Cafeteria Plan Benefit Dollars"** means the amount available to Participants to purchase Benefit Options as provided under Section 4.1. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

1.4 **"Code"** means the Internal Revenue Code of 1986, as amended or replaced from time to time.

1.5 **"Compensation"** means the amounts received by the Participant from the Employer during a Plan Year.

1.6 **"Dependent" in the singular or plural**, means any individual who qualifies as a dependent under the self-funded plan for purposes of that plan or under Code Section 152 (as modified by Code Section 105(b)).

"Dependent" shall include any Child of a Participant who is covered under an Insurance Contract or under the Health Care Flexible Spending Arrangement or as allowed by reason of the Affordable Care Act.

For purposes of the Health Care Flexible Spending Arrangement, a Participant's "Child" includes a biological child, stepchild, foster child, adopted child, or a child placed with the Participant for adoption. A Participant's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the calendar year.

The phrase "placed for adoption" refers to a child whom the Participant intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the

child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

1.7

1.8 **"Election Period"** means the period immediately preceding the beginning of each Plan Year established by the Administrator, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to Section 5.1.

1.9 **"Eligible Employee"** means any Employee who has satisfied the provisions of Section 2.1.

An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation.

1.10 **"Employee"** means any person who is employed by the Employer. The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

1.11 **"Employer"** means any Participating Employer who participates in and receives Benefits under the Plan administered by the Administrator.

1.12 **"Insurance Contract"** means any contract issued by an Insurer underwriting a Benefit.

1.13 **"Insurer"** means any insurance company that underwrites a Benefit under this Plan or, with respect to any self-funded benefits, the Employer.

1.14 **"Key Employee"** means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

1.15 **"Participant"** means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.

1.16 **"Participating Employer"** means any state agency, university, school district, political subdivision, or other entity as defined in I.C. 67-5767.

1.17 **"Plan"** means this cafeteria plan document, including all amendments thereto.

1.18 **"Plan Year"** means the 12-month period beginning July 1 and ending June 30. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

1.19 **"Premiums"** mean the Participant's cost for the self-funded Benefits described in Section 4.1.

1.20 **"Premium Conversion Benefit"** means the account established for a Participant pursuant to this Plan to which part of the Participant's Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant shall be paid or reimbursed. If more than one type of insured or self-funded Benefit is elected, sub-accounts shall be established for each type of insured or self-funded Benefit.

1.21 **"Salary Redirection"** means the contributions made by the Employer on behalf of Participants pursuant to Section 3.1. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

1.22 **"Salary Redirection Agreement"** means an agreement between the Participant and the Employer under which the Participant agrees to reduce their Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

1.23 **"Spouse"** means spouse as determined under Federal law.

1.24 **"Treasury"** means the United States Department of the Treasury.

ARTICLE II PARTICIPATION

2.1 ELIGIBILITY

Any Eligible Employee shall be eligible to participate hereunder as of the date the Employee satisfies the eligibility conditions for the Employer's group medical plan, the provisions of which are specifically incorporated herein by reference. Eligibility criteria is detailed in each plan document for each plan type available to Participants. Plan documents are available through the Insurer and the Administrator. However, any Eligible Employee who was a Participant in the Plan on the effective date of this Cafeteria Plan Document shall continue to be eligible to participate in the group medical plan until they decline the benefit or lose eligibility for the benefit.

2.2 EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee shall become a Participant effective as of the entry date under the Employer's group medical plan.

2.3 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate in a manner set forth by the Administrator. The election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change the Benefit elections pursuant to Section 5.4 hereof.

An Eligible Employee shall also be required to complete a Salary Redirection Agreement during the Election Period for the Plan Year during which the Employee wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to Section 2.2.

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured or self-funded Benefits under this Plan shall automatically become a Participant with respect to paying Premiums for such insurance unless the Employee elects, during the Election Period, not to participate in the Plan.

2.4 TERMINATION OF PARTICIPATION

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

- (a) **Termination of employment.** The Participant's termination of employment, subject to the provisions of Section 2.5;
- (b) **Death.** The Participant's death, subject to the provisions of Section 2.6; or
- (c) **Termination of the plan.** The termination of this Plan, subject to the provisions of Section 10.2.

2.5 TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason other than death, participation in the Benefit Options provided under Section 4.1 shall be governed in accordance with the following:

- (a) **Insurance Benefit.** With regard to Benefits provided under Section 4.1, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract or self-funded benefit for which premiums have already been paid.
- (b) **Day Care FSA.** With regard to the Day Care Flexible Spending Arrangement provided under Article VII of this Plan, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment related Day Care Expense reimbursements for claims incurred through the remainder of the Plan Year in which such termination occurs and submitted within ninety (90) days after the end of the Plan Year, based on the level of the Participant's Day Care Flexible Spending Arrangement as of the date of termination.

(c) **COBRA applicability.** With regard to the Health Care Flexible Spending Arrangement provided under Article VI of this Plan, the Participant may submit claims for expenses that were incurred during the portion of the Plan Year before the end of the period for which payments to the Health Care Flexible Spending Arrangement have already been made. Thereafter, the health benefits under this Plan including the Health Care Flexible Spending Arrangement shall be applied and administered consistent with such further rights a Participant and their Dependents may be entitled to pursuant to Code Section 4980B and Section 11.13 of the Plan.

2.6 DEATH

If a Participant dies, participation in the Plan shall cease. However, such Participant's Spouse or Dependents may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to each specific benefit are exhausted; whichever comes first. In no event may reimbursements be paid to someone who is not a spouse or Dependent. If the Plan is subject to the provisions of Code Section 4980B, then those provisions and related regulations shall apply for purposes of the Health Care Flexible Spending Arrangement.

ARTICLE III CONTRIBUTIONS TO THE PLAN

3.1 SALARY REDIRECTION

Benefits under the Plan shall be financed by Salary Redirections sufficient to support Benefits that a Participant has elected hereunder and to pay the Participant's Premiums. The salary administration program of the Employer shall be revised to allow each Participant to agree to reduce Participant's pay during a Plan Year by an amount determined by the Administrator as necessary to purchase the elected Benefit Options. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article IV.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Article V of the Plan, and consistent with the rules and regulations of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

3.2 APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Care Flexible Spending Arrangement or Day Care Flexible Spending Arrangement shall be credited to such fund or account. Amounts designated for the Participant's Premium Conversion Benefit shall likewise be credited to such account for the purpose of paying Premiums.

3.3 PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Participant on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Care Flexible Spending Arrangement, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year.

ARTICLE IV BENEFITS

4.1 BENEFIT OPTIONS

Each Participant may elect any one or more of the following optional Benefits:

- (1) Health Care Flexible Spending Arrangement
- (2) Day Care Flexible Spending Arrangement

In addition, each Participant shall have a sufficient portion of their Salary Redirections applied to the following Benefits unless the Participant elects not to receive such Benefits:

- (3) Health Insurance Benefit
- (4) Dental Insurance Benefit
- (5) Vision Insurance Benefit

4.2 HEALTH CARE FLEXIBLE SPENDING ARRANGEMENT BENEFIT

Each Participant may elect to participate in the Health Care Flexible Spending Arrangement option, in which case Article VI shall apply.

4.3 DAY CARE FLEXIBLE SPENDING ARRANGEMENT BENEFIT

Each Participant may elect to participate in the Day Care Flexible Spending Arrangement option, in which case Article VII shall apply.

4.4 HEALTH INSURANCE BENEFIT

(a) **Coverage for Participant and Dependents.** Each Participant may elect to be covered under the Insurance Contract individually, or may elect to have the coverage that also include Participant's Spouse and Participant's Dependent(s)

(b) **Administrator selects contracts.** The Administrator may select suitable health Insurance Contracts for use in providing this health insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such health Insurance Contract shall be determined therefrom, and such health Insurance Contract shall be incorporated herein by reference.

4.5 DENTAL INSURANCE BENEFIT

(a) **Coverage for Participant and Dependents.** Each Participant may elect to be covered under the Administrator's dental Insurance Contract. In addition, the Participant may elect either individual or family coverage under such Insurance Contract.

(b) **Administrator selects contracts.** The Administrator may select suitable dental Insurance Contracts for use in providing this dental insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such dental Insurance Contract shall be determined therefrom, and such dental Insurance Contract shall be incorporated herein by reference.

4.6 VISION INSURANCE BENEFIT

(a) **Coverage for Participant and/ Dependents.** Each Participant may elect to be covered under the Administrator's vision Insurance Contract. In addition, the Participant may elect either individual or family coverage.

(b) **Administrator selects contracts.** The Administrator may select suitable vision Insurance Contracts for use in providing this vision insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such vision Insurance Contract shall be determined therefrom, and such vision Insurance Contract shall be incorporated herein by reference.

4.7 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Plan not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) **25% concentration test.** It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) may be considered part of gross income.

(c) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination under this Plan or possible taxation to Key Employees or a group of employees not to discriminate in violation of the Code and the Treasury regulations thereunder, it may, but shall not be required to, reduce contributions or non-taxable Benefits in order to assure compliance with the Code and regulations. Any act taken by the Administrator shall be carried out in a uniform and nondiscriminatory manner. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Care Flexible Spending Arrangement Benefits and Day Care Flexible Spending Arrangement Benefits, and once all these Benefits are expended, proportionately among self-funded Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

ARTICLE V PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided the Employee elects to do so on or before the effective date of participation pursuant to Section 2.2.

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured or self-funded benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance unless the Employee elects, during the Election Period, not to participate in the Plan.

5.2 SUBSEQUENT ANNUAL ELECTIONS

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form to be provided by the Administrator, which spending account Benefit options the Participant wishes to select. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

(a) A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

(b) A Participant may terminate participation in the Plan by notifying the Administrator in writing during the Election Period that the Participant does not want to participate in the Plan for the next Plan Year;

(c) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Section 5.4.

5.3 FAILURE TO ELECT

With regard to Benefits available under the Plan for which no Premiums apply, any Participant who fails to complete a new benefit election form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized or made for the subsequent Plan Year for such Benefits.

With regard to Benefits available under the Plan for which Premiums apply, any Participant who fails to complete a new benefit election form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have made the same Benefit elections as are then in effect for the current Plan Year. The Participant shall also be deemed to have elected Salary Redirection in an amount necessary to purchase such Benefit options.

5.4 CHANGE IN STATUS

(a) **Change in status defined.** Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are consistent with a change in status which is acceptable under the applicable rules and regulations adopted by the Treasury, the provisions of which are incorporated herein by this reference. Notwithstanding anything herein to the contrary, if the rules and regulations of the Treasury conflict with this Plan, then such rules and regulations shall control.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, Spouse or Dependent gains or loses eligibility for coverage, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

Regardless of the consistency requirement, if the individual, the individual's Spouse, or the individual's Dependent becomes eligible for continuation coverage under the Administrator's Insurance Contract as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

- (1) Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;
- (2) Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;
- (3) Employment Status: Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Participant's Spouse, or Participant's Dependent(s) depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

(4) **Dependent satisfies or ceases to satisfy the eligibility requirements:** An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and

(5) **Residency:** A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of coverage).

(6) **Adoption Assistance:** For purposes of adoption assistance provided through a cafeteria plan, the commencement or termination of an adoption proceeding.

For the Day Care Flexible Spending Arrangement, a Dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child, as allowed under Code Sections 105(b) and 106, and guidance thereunder, shall qualify as a change in status.

(b) **Special enrollment rights.** Notwithstanding subsection (a), the Participants may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP); provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

(c) **Qualified Medical Support Order.** Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement) ("order") resulting from a divorce, legal separation, annulment, or change in legal custody which requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan and such coverage is actually provided.

(d) **Medicare or Medicaid.** Notwithstanding subsection (a), a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

(e) **Cost increase or decrease.** If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Administrator.

(f) **Loss of coverage.** If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

(g) **Addition of a new benefit.** If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

(h) **Loss of coverage under certain other plans.** A Participant may make a prospective election change to enroll in the group health coverage provided by the Administrator for the Participant, the Participant's Spouse, or the Participant's Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program (CHIP) under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

(i) **Change of coverage due to change under certain other plans.** A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's or Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse's, former Spouse's or Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse's or Dependent's employer.

(j) **Change in Day Care provider.** A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the Day Care provider. The availability of Day Care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Day Care Flexible Spending Arrangement only if the cost change is imposed by a Day Care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).

(k) **Health FSA cannot change due to insurance change.** A Participant shall not be permitted to change an election to the Health Care Flexible Spending Arrangement as a result of a cost or coverage change under any health insurance benefits.

(l) **Changes due to reduction in hours or enrollment in an Exchange Plan.** A Participant may prospectively revoke coverage under the group health plan (that is not a Health Care Flexible Spending Arrangement) which provides minimum essential coverage (as defined in Code Section 5000A(f)(1)) provided the following conditions are met:

Conditions for revocation due to reduction in hours of service:

- (1) The Participant has been reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the group health plan; and
- (2) The revocation of coverage under the group health plan corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

The Administrator may rely on the reasonable representation of the Participant who is reasonably expected to have an average of less than 30 hours of service per week for future periods that the Participant and related individuals have enrolled in or intend to enroll in another plan that provides minimum essential coverage for new coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

Conditions for revocation due to enrollment in a Qualified Health Plan:

- (1) The Participant is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace (federal or state exchange) pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant

seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

(2) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the revocation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

The Administrator may rely on the reasonable representation of a Participant who has an enrollment opportunity for a Qualified Health Plan through a Marketplace that the Participant and related individuals have enrolled in or intend to enroll in a Qualified Health Plan for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

ARTICLE VI HEALTH CARE FLEXIBLE SPENDING ARRANGEMENT

6.1 ESTABLISHMENT OF PLAN

This Health Care Flexible Spending Arrangement is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Care Flexible Spending Arrangement may submit claims for the reimbursement of Medical Expenses, defined below. All amounts reimbursed shall be periodically paid from amounts allocated to the Health Care Flexible Spending Arrangement. Periodic payments reimbursing Participants from the Health Care Flexible Spending Arrangement shall occur at least monthly..

6.2 DEFINITIONS

The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Care Flexible Spending Arrangement. In addition, for the purposes of this Article and the Cafeteria Plan, the terms below have the following meaning:

(a) **"Health Care Flexible Spending Arrangement"** means the account established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by a Participant, or Participant's Spouse or Participant's Dependents, may be reimbursed.

(b) **"Highly Compensated Participant"** means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

- (1) one of the 5 highest paid Officers;
- (2) a shareholder who owns (or is considered to own, in applying the rules of Code Section 318) more than ten (10) percent in value of the stock of the Employer; or
- (3) among the highest paid twenty-five (25) percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

(c) **"Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining tax liability under the Code. "Medical Expenses" can be incurred by the Participant, Participant's Spouse and Participant's Dependents. "Incurred" means, with regard to Medical Expenses, when the Participant is provided with the medical care that gives rise to the Medical Expenses and not when the Participant is formally billed or charged for, or pays for, the medical care.

6.3 PROHIBITED REIMBURSEMENTS

A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or Participant's Spouse or Participant's Dependent.

A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

6.4 FORFEITURES

The amount in the Health Care Flexible Spending Arrangement as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6.8 below, excluding any carryover) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, pursuant to Section 8.2.

6.5 LIMITATION ON ALLOCATIONS

(a) Notwithstanding any provision contained in this Health Care Flexible Spending Arrangement to the contrary, the maximum amount that may be allocated to the Health Care Flexible Spending Arrangement by a Participant in or on account of any Plan Year is determined by the Administrator, but not in excess of the Federal maximum.

(b) **Participation in Other Plans.** All employers that are treated as a single employer under Code Sections 414(b), (c), or (m), relating to controlled groups and affiliated service groups, are treated as a single employer for purposes of the statutory limit contained in Code §125(i) and updated annually. If a Participant participates in multiple cafeteria plans offering Health Care Flexible Spending Arrangements maintained by members of a controlled group or affiliated service group, the Participant's total Health Care Flexible Spending Arrangement contributions under all of the cafeteria plans are limited to the statutory limit (as adjusted). However, a Participant employed by two or more employers that are not members of the same controlled group may elect up to the statutory limit (as adjusted) under each Employer's Health Care Flexible Spending Arrangement.

(c) **Carryover.** A Participant in the Health Care Flexible Spending Arrangement may roll over up to \$500 of unused amounts in the Health Care Flexible Spending Arrangement remaining at the end of one Plan Year to the immediately following Plan Year. These amounts can be used during the following Plan Year for expenses incurred in that Plan Year. Amounts carried over do not affect the maximum amount of salary redirection contributions for the Plan Year to which they are carried over. Unused amounts are those remaining after expenses have been reimbursed during the runout period. These amounts may not be cashed out or converted to any other taxable or nontaxable benefit. Amounts in excess of \$500 will be forfeited, pursuant to Section 6.4. The Plan is permitted, but not required, to treat claims as being paid first from the current year amounts, then from the carryover amounts.

6.6 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** . It is the intent of this Health Care Flexible Spending Arrangement that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under the Code and the Treasury regulations thereunder.

(b) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination under this Health Care Flexible Spending Arrangement, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in an any manner the Administrator deems necessary. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

6.7 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Health Care Flexible Spending Arrangement.

6.8 HEALTH CARE FLEXIBLE SPENDING ARRANGEMENT CLAIMS

(a) **Expenses must be incurred during Plan Year.** All Medical Expenses incurred by a Participant, Participant's Spouse and Participant's Dependents during the Plan Year shall be reimbursed during the Plan Year, subject to Section 2.5, even though the submission of such a claim occurs after Participant's participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed, charged for, or pays for the medical care.

(b) **Reimbursement available throughout Plan Year.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses up to a maximum of the amount designated by the Participant for the Health Care Flexible Spending Arrangement for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant, Participant's Spouse and/or Participant's Dependents.

(c) **Payments.** Reimbursement under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for reimbursement or direct payment to the service provider shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from the provider stating that the Medical Expenses have been incurred and providing the amount of such expenses. Furthermore, the Participant shall provide a written statement that the Medical Expenses have not been reimbursed, they are not reimbursable under any other health plan coverage, and if reimbursed from the Health Care Flexible Spending Arrangement, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

(d) **Time limit on claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon as is administratively practicable after a claim has been filed; provided however, that if a Participant fails to submit a claim within one hundred and twenty three (123) days after the end of the Plan Year, that claim for Medical Expenses shall not be considered for reimbursement by the Administrator.

6.9 DEBIT AND CREDIT CARDS

Participants may, subject to the procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use a debit and/or credit (stored value) card ("card") issued by the Administrator and permitted by this Plan for payment of Medical Expenses, subject to the following terms:

(a) **Card only for Medical Expenses.** Each Participant who is issued a card shall certify that such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expenses paid with the card have not already been reimbursed by any other plan covering health benefits, and that the Participant will not seek reimbursement of Medical Expenses paid with the card from any other plan covering health benefits.

(b) **Card issuance.** The card shall be issued upon the Participant's Effective Date of Participation and reissued for each Plan Year the Participant remains a Participant in the Health Care Flexible Spending Arrangement. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or when such Participant has a change in status that results in the Participant's withdrawal from the Health Care Flexible Spending Arrangement.

(c) **Maximum dollar amount available.** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in Section 6.5.

(d) **Only available for use with certain service providers.** The card shall only be accepted by such merchants and service providers as have been approved by the Administrator and as referenced in IRS Publication 969.

(e) **Card use.** The card shall only be used for Medical Expenses that include, but are not limited to, the following:

- (1) Co-payments for doctor and other medical care;
- (2) Purchase of drugs prescribed by a health care provider, including, if permitted by the Administrator, over-the-counter medications as allowed under IRS regulations; referenced in IRS Publication 969.
- (3) Purchase of medical items such as eyeglasses, syringes, crutches, etc.

(f) **Substantiation.** Payments made using the card shall be subject to substantiation by the Administrator, by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

(g) **Correction methods.** If such purchase is later determined by the Administrator to not qualify as Medical Expenses, the Administrator, in its discretion, shall use one of the below correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card. The corrections methods available the Administrator are as follows:

- (1) Repayment of the improper amount by the Participant;
- (2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;
- (3) Claims substitution or offset of future claims until the amount is repaid; and
- (4) If subsections (1) through (3) fail to recover the amount, the Administrator may treat the amount as any other business indebtedness consistent with the Administrator's business practices.

ARTICLE VII DAY CARE FLEXIBLE SPENDING ARRANGEMENT

7.1 ESTABLISHMENT OF ACCOUNT

This Day Care Flexible Spending Arrangement is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Day Care Expenses, defined below. All amounts reimbursed shall be paid from amounts allocated to the Participant's Day Care Flexible Spending Arrangement.

7.2 DEFINITIONS

The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Day Care Flexible Spending Arrangement. In addition, for the purposes of this Article and the Cafeteria Plan, the terms below shall have the following meaning:

- (1) **"Day Care Flexible Spending Arrangement"** means the account established for a Participant pursuant to this Article to which part of Participant's Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Day Care Expenses of the Participant may be reimbursed for the care of Participant's Qualifying Dependent.
- (2) **"Earned Income"** means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for day care assistance to the Participant.
- (3) **"Employment-Related Day Care Expenses"** means the amounts paid for expenses of a

Participant for those services which, if paid by the Participant, would be considered employment related expenses under Code Section 21(b)(2). Generally, such expenses shall include those for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which Participant has one or more Qualifying Dependents. Employment-Related Day Care Expenses are treated as having been incurred when the Participant's Qualifying Dependent is provided with the day care that gives rise to the Employment-Related Day Care Expenses, not when the Participant is formally billed or charged for, or pays for the day care. The determination of whether an amount qualifies as an Employment-Related Day Care Expense shall be made subject to the following rules:

- (1) If such amounts are paid toward expenses incurred outside the Participant's household, such shall constitute Employment-Related Day Care Expenses only if incurred for a Qualifying Dependent as defined below in Section 7.2(d) who regularly spends at least eight (8) hours per day in the Participant's household;
 - (2) If the expense is incurred outside the Participant's household at a facility that provides care for a fee, payment, or grant for more than six (6) individuals who do not regularly reside at the facility, the facility must comply with all applicable federal, state, and local laws, rules, and regulations, including any licensing requirements; and
 - (3) Employment-Related Day Care Expenses of a Participant shall not include amounts paid to or incurred by a child of such Participant who is under the age of nineteen (19) or to an individual who is Participant's Dependent or Participant's Spouse.
- (4) **"Qualifying Dependent"** means, for Day Care Flexible Spending Arrangement purposes,
- (1) a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age thirteen (13);
 - (2) a Participant's Dependent or Spouse who is physically or mentally incapable of caring for himself or herself and has the same principal household as the Participant for more than one-half of such taxable year; or
 - (3) a child that is deemed to be a Qualifying Dependent, as described above in subsections (1) or (2), pursuant to Code Section 21(e)(5).

7.3 DAY CARE FLEXIBLE SPENDING ARRANGEMENTS

The Administrator shall establish a Day Care Flexible Spending Arrangement for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Day Care Flexible Spending Arrangement benefits.

7.4 INCREASES IN DAY CARE FLEXIBLE SPENDING ARRANGEMENTS

A Participant's Day Care Flexible Spending Arrangement shall be increased each pay period by the portion of Cafeteria Plan Benefit Dollars that Participant has elected to apply toward the Day Care Flexible Spending Arrangement pursuant to elections made under Article V hereof.

7.5 DECREASES IN DAY CARE FLEXIBLE SPENDING ARRANGEMENTS

A Participant's Day Care Flexible Spending Arrangement shall be reduced by the amount of any Employment-Related Day Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section 7.12 below.

7.6 ALLOWABLE DAY CARE REIMBURSEMENT

Subject to limitations contained in Section 7.9 below, and to the extent of the amount contained in the Participant's Day Care Flexible Spending Arrangement, a Participant who incurs Employment-Related Day Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which Participant remains a Participant under the Plan.

7.7 ANNUAL STATEMENT OF BENEFITS

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under Section 7.6 during the prior calendar year, a statement of all such contributions collected on behalf of such Participant during the prior calendar year. This statement is set forth on the Participant's Form W-2.

7.8 FORFEITURES

The amount in a Participant's Day Care Flexible Spending Arrangement at the end of any Plan Year, including any grace periods (and after the processing of all claims for such Plan Year, pursuant to Section 7.12 below) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, pursuant to Section 8.2.

7.9 LIMITATION ON PAYMENTS

(1) **Code limits.** Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Day Care Flexible Spending Arrangement in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or \$5,000 (\$2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

7.10 NONDISCRIMINATION REQUIREMENTS

(1) **Intent to be nondiscriminatory.** It is the intent of this Day Care Flexible Spending Arrangement that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d).

(2) **25% test for shareholders.** It is the intent of this Day Care Flexible Spending Arrangement that not more than twenty-five percent (25%) of the amounts paid by the Employer for day care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than five percent (5%) of the stock, capital, or profits interest in the Employer.

(3) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in a uniform and nondiscriminatory manner.

7.11 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Day Care Flexible Spending Arrangement. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Day Care Flexible Spending Arrangement. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

7.12 DAY CARE FLEXIBLE SPENDING ARRANGEMENT CLAIMS

(a) **Claims for reimbursement.** The Administrator shall direct the reimbursement of all such day care claims to the Participant upon presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be made directly to the service provider. In its discretion in

administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred during the Plan Year and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Day Care Expenses submit a statement which may include some or all of the following information:

- (1) The Dependent(s) for whom the services were performed;
- (2) The nature of the services performed for the Participant;
- (3) The relationship to the Participant, if any, of the person performing the services;
- (4) If the services are being performed by a child of the Participant, the age of the child;
- (5) A statement as to the location where the services were performed;
- (6) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least eight (8) hours a day in the Participant's household;
- (7) If the services were performed in a day care center, a statement containing the following:
 - (i) that the day care center complies with all applicable laws, rules, and regulations of the state of residence;
 - (ii) that the day care center provides care for more than (6) individuals (other than individuals residing at the center); and
 - (iii) the amount of fee paid to the provider.
- (8) If the Participant is married, a statement containing the following:
 - (i) the Spouse's salary or wages if the Spouse is employed; or
 - (ii) if the Participant's Spouse is not employed, include one of the following:
 - (a) that the Spouse is incapacitated; or
 - (b) that the Spouse is a full-time student attending an educational institution, and provide the months during the year which the Spouse attended such institution.

- (a) (b) **Time limit on claims for reimbursement.**
 - (b) Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon as is administratively practicable after a claim has been filed; provided however, that if a Participant fails to submit a claim within one-hundred and twenty-three (123) days after the end of the Plan Year, that claim for day care expenses shall not be considered for reimbursement by the Administrator.

ARTICLE VIII BENEFITS AND RIGHTS

8.1 CLAIM FOR BENEFITS

- (a) **Insurance claims.** Any claim for Benefits underwritten by Insurance Contract(s) shall be made to the Insurer. If the Insurer denies any claim, the Participant or beneficiary shall follow the Insurer's claims review procedure.
- (b) **Health and Day Care Flexible Spending Arrangement Claims.** The Participant must submit all claims no later than one-hundred and twenty-three (123) days after the end of the Plan Year.

Any claims submitted after that time will not be considered.

8.2 NOTIFICATION AND APPEAL PROCESS

If a claim is approved it is paid by direct deposit, check, debit card approval, or payment direct to provider (if applicable). If a claim under the Plan is denied in whole or in part, the Participant will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim, and an explanation of the claims review procedure.

A level one appeal must be submitted within one-hundred and eighty (180) days of receipt of the denial. Any such request should be accompanied by documents or records in support of the appeal. The Participant may review pertinent documents and submit issues and comments in writing. The claims administrator will review the claim and provide, within thirty (30) days, a written response to the appeal (extended by a reasonable time if necessary). In this response, the claims administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. If the Participant disagrees with the level one appeal decision, the Participant may submit a request for a level two appeal to be determined by the Administrator. The Participant must submit the request for a level two appeal within sixty (60) days of receipt of the level one notice. The Participant will be notified within thirty (30) days after the Administrator receives the appeal (extended by reasonable time if necessary). The Administrator has the exclusive right to interpret the appropriate plan provisions. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan. Decisions of the Administrator are final and binding.

8.3 APPLICATION OF BENEFIT PLAN SURPLUS

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or to seek reimbursement in a timely manner may, although not required, be separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan (excepting any carryover); nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as may be permitted by Treasury regulations. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses, and shall be used to provide additional benefits under the Plan.

ARTICLE IX ADMINISTRATION

9.1 PLAN ADMINISTRATION

The Administrator may designate a third party to administer the Plan on behalf of the Administrator. The Participating Employer is responsible for the collection of Participant contributions under the Plan and remitting such amounts to the Administrator or its designee. The Administrator shall be empowered to remove any third party as it deems necessary for the proper administration of the Plan and to ensure that the Plan is being operated for the exclusive benefit of the Employees entitled to participate in the Plan, in accordance with the terms of the Plan and the Code.

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power and discretion to administer the Plan in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconcile any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the Plan. The Administrator shall have all powers necessary or appropriate to accomplish the Administrator's duties under the Plan. In addition to all other powers provided by this Plan, the Administrator shall be charged with the duties of the general administration of the Plan as set forth herein, including, but not limited to,:

- (a) Make and enforce such procedures, rules, and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

(b) Interpret the provisions of the Plan in good faith, where such interpretations shall be final and binding on all persons claiming benefits under the Plan;

(c) Decide all questions concerning the Plan and concerning the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;

(d) Reject elections or limit contributions or Benefits for certain highly compensated participants if the Administrator deems such to be desirable in order to avoid discrimination under the Plan;

(e) Provide Employees with a reasonable notification of their benefits available under the Plan and assist any Participant regarding the Participant's rights, benefits, or elections under the Plan;

(f) Keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;

(g) Review and settle all claims against the Plan, approve reimbursement requests, and authorize the payment of benefits to Participants or service providers if the Administrator determines in its discretion that such shall be paid. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan; and

(h) Appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation, or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

9.2 EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee, and any other Employee of the Employer such records as may pertain to their interest under the Plan for examination at reasonable times during normal business hours.

9.3 PAYMENT OF EXPENSES

Any reasonable administrative expenses shall be paid by the Administrator unless the Administrator determines that administrative costs shall be borne by the Participants under the Plan or by any trust fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

9.4 INSURANCE CONTROL CLAUSE

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third-party Insurer in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to, and the circumstances under which the Insurance Contract terminates.

**ARTICLE X
AMENDMENT OR TERMINATION OF PLAN**

10.1 AMENDMENT

The Administrator may, at any time, amend any or all provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state, or local laws, rules, or regulations.

10.2 TERMINATION

The Administrator reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Insurance Contract shall be paid in accordance with the terms of the Insurance Contract.

No further contributions shall be made to the Health Care Flexible Spending Arrangement or Day Care Flexible Spending Arrangement, but all payments from Employee contributions made pursuant to either Arrangement shall continue to be made according to the elections in effect until ninety (90) days after the termination date of the Plan. Any amounts remaining in any such fund or account at the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

**ARTICLE XI
MISCELLANEOUS**

11.1 PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 11.11 below.

11.2 SINGULAR AND PLURAL TERMS

Whenever any words are used herein in the singular form, they shall be construed as though they were also used in the plural form in all cases where such would apply.

11.3 WRITTEN DOCUMENT

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

11.4 EXCLUSIVE BENEFIT

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan as Participants.

11.5 PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant, or to be consideration for or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer, or to interfere with the right of the Employer to discharge any Participant or Employee.

11.6 ACTION BY THE EMPLOYER

Whenever the Employer is permitted or required to do or perform any act or matter under the terms of the Plan, such shall be performed by a person duly authorized by its legally constituted authority.

11.7 NO GUARANTEE OF TAX CONSEQUENCES

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to the Participant or for the Participant's benefit under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes. It shall be the Participant's obligation to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

11.8 LIABILITY FOR TAX CONSEQUENCES

If any Participant receives one or more payments or reimbursements under the Plan on a pre-tax Salary Redirection basis, and such payments do not qualify for such treatment under the Code, the Participant shall indemnify and reimburse the Employer for any liability the Employer may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

11.9 FUNDING

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

11.10 GOVERNING LAW

This Plan is governed by the Code and the Treasury regulations (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of Idaho.

11.11 SEVERABILITY

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

11.12 HEADINGS

The headings contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor shall they in any way affect this Plan or the construction of any provision herein.

11.13 CONTINUATION OF COVERAGE (COBRA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of 42 U.S.C. Section 300bb-1 becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B, and related regulations. This Section shall only apply if the Employer employs at least twenty (20) employees on more than 50% of its typical business days in the previous calendar year.

11.14 FAMILY AND MEDICAL LEAVE ACT (FMLA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with 26 CFR Section 1.125-3.

11.15 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and the regulations thereunder.

11.16 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniform Services Employment and Reemployment Rights Act (USERRA) and the regulations thereunder.

11.17 COMPLIANCE WITH HIPAA PRIVACY STANDARDS

(a) **Application.** If any benefits under this Cafeteria Plan are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.

(b) **Disclosure of Protected Health Information.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(c) **Protected Health Information disclosed for administrative purposes.** Protected Health Information disclosed to members of the Employer's workforce may be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.

(d) **Protected Health Information disclosed to certain workforce members.** The Plan may disclose Protected Health Information only to members of the Employer's workforce who are designated and authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform their duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

(1) An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform their duties with respect to the Plan.

(2) In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy official. The privacy official shall take appropriate action, including:

(i) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

(iii) mitigation of any harm caused by the breach, to the extent practicable; and

(iv) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(e) **Certification.** The Employer must provide certification to the Administrator that it agrees to:

- (1) Not use or disclose the information other than as permitted or required by the Plan documents or as required by law;
- (2) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
- (3) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- (4) Report to the Administrator any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;
- (5) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
- (6) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
- (7) Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
- (8) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information available to the Department of Health and Human Services upon request for purposes of determining compliance by the Plan with the Privacy Standards;
- (9) If feasible, return or destroy all Protected Health Information that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- (10) Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above.

11.18 COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 *et. seq.*, the "Security Standards"):

- (a) **Implementation.** The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- (b) **Agents or subcontractors shall meet security standards.** The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (c) **Employer shall ensure security standards.** The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Section 11.17.

11.19 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act.

11.20 GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

11.21 WOMEN'S HEALTH AND CANCER RIGHTS ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Women's Health and Cancer Rights Act .

11.22 NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Newborns' and Mothers' Health Protection Act.

IN WITNESS WHEREOF, this Plan document is hereby executed this 4th day of January, 2023.

State of Idaho Department of Administration - Office of
Group Insurance

By Kaitlin Reynolds
ADMINISTRATOR

ADOPTING RESOLUTION

The undersigned authorized representative of State of Idaho Department of Administration - Office of Group Insurance (the Administrator) hereby certifies that the following resolutions were duly adopted by the Administrator on 1/4/2023, and that such resolutions have not been modified or rescinded as of the date hereof:

RESOLVED, that the form of amended Cafeteria Plan including a Health Flexible Spending Account and Dependent Care Flexible Spending Account effective July 1, 2016, presented to this meeting is hereby approved and adopted and that an authorized representative of the Employer is hereby authorized and directed to execute and deliver to the Administrator of the Plan one or more counterparts of the Plan.

The undersigned further certifies that attached hereto as Exhibits A and B, respectively, are true copies of State of Idaho Department of Administration - Office of Group Insurance as amended and restated, and the Summary Plan Description approved and adopted in the foregoing resolutions.

Date: 1/4/2023

Signed: Keith Reynolds

Keith Reynolds, Director
[print name/title]